Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST LLC
PO BOX 890008
HOUSTON TX 77289

Respondent Name

NATIONAL AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-1459-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…After receiving preauthorization from the carrier's URA, and a payment of one claim, the carrier decided to deny the remaining claims based upon a peer review performed. However, according to the code, a preauthorized service, once preauthorized, cannot be rescinded nor denied based upon a peer review…"

Amount in Dispute: $1184.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None received. The respondent was notified of the dispute on January 18, 2011 with a response due by February 2, 2011. As of the undersigned date, no response has been received.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 24, 29, 2010	90806	$1184.10	$412.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. On December 13, 2011, the division 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the guidelines for medical payments and denials.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated July 7 and 13, 2010
   - 216 Based on the findings of a review organization

Explanation of benefits dated July 20, 2010

- 50 – Service not deemed a 'medical necessity' by payer
- 201 – Workers Comp case settled

Explanation of benefits dated November 8, 2010

- 080 – denied per carrier
- 193 – Original payment decision maintained
- 216 – Based on the findings of a review organization

Issues

1. Were the disputed services preauthorized?
2. Is the requestor entitled to reimbursement?

Findings

1. On December 13, 2011, the division received a letter of withdrawal for CPT code 90801 for date of service May 20, 2010. The remaining disputed amount is $442.68.
2. 28 Texas Administrative Code §133.307(a)(3) states, "In resolving non-network disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division of Workers Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules." The respondent denied the disputed services based on the findings of a review organization and not medically necessary. The requestor submitted a copy of preauthorization #1055376 F 1 which states, "…reconsideration of Forte's NON_AUTHORIZATION of outpatient individual psychotherapy (IPT) one (1) time a week for six (6) weeks as related to the lumbar spine. Original decision OVERTURNED. Recommend AUTHORIZATION." The denial reason is not supported. The provisions of 28 Texas Administrative Code §133.240 state, "for health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits – Guidelines for Medical Services, Charges, and Payments).
3. The requestor seeks reimbursement for CPT code 90806 which was preauthorized by the insurance carrier; therefore, recommend reimbursement as follows: DWC conversion factor $54.32 ÷ Medicare conversion factor $36.8729 x participating amount $93.37 = $137.55 x 3 DOS = $412.65.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $412.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to reimbursement for the disputed services. The Division hereby ORDERS the respondent to remit to the requestor the amount of $412.65 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 22, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.